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Clinical Case Studies

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FOREWORD

The object of these studies is to afford practice in the formulation of a diagnosis on the basis of the history and physical findings, together with such technical procedures, X-ray studies, and opinions of specialists as may seem to be indicated. Actual case records are used, unchanged except for the deletion of identifying names and such editing as may seem advisable for the sake of brevity and clearness.

DIRECTIONS

Proceed on the basis that each case is a patient under your own care. The general history and physical findings as printed in this supplement represent what you would learn from the first visit of the patient in your office. After studying these make up your mind as to the most likely working diagnosis and put this in writing in the space provided for "Notes", this being solely for your own reconsideration in light of later information. Select the enclosed post card correspondingly numbered with the case problem you are studying and check off on the card the special procedures which you feel are definitely indicated; do not ask for everything blindly but for only such studies as you would order if this were your own private patient. Mail the card promptly to the Pittsburgh Diagnostic Clinic, making certain to show your name and address.

You will receive from the Clinic two packets for each case. In one, will be the information you requested, provided it is available. Study this material and make up your mind as to the final diagnosis, putting your opinion in writing on the page provided for "Notes". Then open the second packet which contains the final report made by the Clinic Staff, and follow-up information as to the patient's subsequent clinical course which serves as a check on the accuracy of the diagnosis.

It is particularly urged that you commit yourself in writing at every stage of the study because a comparison of the provisional with the final diagnosis will frequently prove most instructive.

GENERAL HISTORY

White Male Married Age 44 years

CHIEF COMPLAINT

An attack of "acute indigestion" one month ago.

PRESENT ILLNESS

This patient dates his present illness back two months, at which time he developed an almost complete loss of appetite as a result of "a very severe nervous shock." For the following month he found food very distasteful, almost to the point of nausea when it was placed before him, and during this time he noticed increasing weakness and steady loss of weight, totalling 12 pounds. One month ago, after forcing himself to eat a rather distasteful and indigestible lunch at a business conference, he almost immediately developed a sensation of severe epigastric discomfort, gaseous distention, and pain radiating up into the left chest and down the left arm as far as the elbow, these sensations being accompanied also by a feeling of moderate weakness. He continued his duties as store manager for about an hour, by which time the pains were so marked that he went to the first aid station and was given a dose of soda which gave almost complete relief for a half hour; he did not lie down but sat in a chair. When the pain returned he took a second dose of soda and was again relieved for about a half hour. However, the pains returned the third time and then a physician was called who gave him a hypodermic and advised that he lie down. After reclining about an hour he felt quite well but he was taken home on the supposition that his attack may have been due to heart trouble. The family physician saw him that evening at which time he was again complaining of some pain over the heart and down the left arm, but there was no sweating

or other signs of shock. The blood pressure was 155/110. A small dose of morphin by mouth was given and the patient rested comfortably all night. The next morning the blood pressure was 110/80; the patient was free from pain and has remained so to the present time. He was kept at complete rest for four weeks during the first two weeks of which he was on a very limited diet, with a gradual increase in the food intake during the latter two weeks. His weight loss during the two weeks of limitation of diet was 25 pounds, but it has remained stationary in the latter two weeks and he has steadily improved in the general feeling of returning strength and vitality. At the present time he feels perfectly well, there being no shortness of breath, cough, pain in the chest, or sensations of gaseous indigestion. No jaundice at any time.

PAST HISTORY

Typhoid fever at age of 16. At about the age of 21 he had a pulmonary hemorrhage and examination disclosed a right apical tuberculosis, this being treated by pneumothorax which was maintained for one year, during which he became entirely free from all symptoms. However, he did gain weight markedly during this period due to the forced feeding, his weight going up to an average of 215. Since recovery from that one episode he has had no pulmonary symptoms of any kind.

Aside from the above he has otherwise always been perfectly well. However, he has been overweight, varying from 210 to 226, since the pulmonary tuberculosis, and has avoided any very active physical exertion.

Habits—regular as to hours of eating and sleeping. He plays golf moderately, smokes about five cigarettes a day, only rarely takes a small drink of whiskey.

Marital history—married, wife is living and well, two children ages 19 and 12, living and well. Wife had a thyroid operation a number of years ago.

Venereal history—entirely negative.

Family history—negative.

PHYSICAL EXAMINATION

GENERAL

Height 73 inches Weight 194 pounds Temperature 98.6°

Patient is tall, large frame, and is still quite obese, although the skin is loose, showing evidence of the loss of weight. There are abnormal deposits of fat under the angles of the jaws. He is noticeably pale, almost of the waxy type, and there is a slight muddy tinge to the sclerae; no true jaundice. There is no evidence of dyspnea or cyanosis. He does not appear introspective or neurotic, but he is evidently of the hyperactive, "nervous drive" type.

HEAD AND NECK

Ears—negative. Eyes—pupils are equal, react normally, moderately positive von Graefe. Mouth—teeth are well preserved, gums are clean. Tongue is protruded in midline and is entirely normal in appearance. Throat appears rather congested, tonsils are deep and appear soft and somewhat edematous, but no definite crypts are visible. Glands—no general enlargement. Thyroid—not enlarged.

THORAX

Moderate impairment of the percussion note over the right upper lung, both front and back, and over this area the breath sounds are bronchial in character and quite intense, but no moisture can be heard. This condition extends down to about the second interspace front and behind. Left lung is moderately impaired over the apex and there is some intensification of breath sounds, but no moisture. Sounds over both bases are clear.

Heart—moderately enlarged down and to the left, the point of maximal impulse being in the fifth interspace, just in the

nipple line; cardiac dullness extends to the sternal border on the right in the fourth interspace and to the third rib above; there is no widening of the cardiac dullness over the base. The heart rate is 78, regular in force and rhythm; heart sounds at the apex are rather soft and blurred, but no definite murmur is heard. Heart sounds over the base are of normal intensity and there are no murmurs. Pulse—78, regular in force and rhythm; no abnormal thickening of radial wall.

ABDOMEN

Liver edge is palpable about one finger breadth below the costal margin, but it is of normal consistency and there is no tenderness. Spleen is not palpable; no tenderness in the abdomen, no masses and no abnormal peristalsis.

EXTREMITIES

No edema; reflexes are all normal; no tremor of the fingers.

BLOOD PRESSURE

Systolic 112.
Diastolic 75.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination.

MY REVISED DIAGNOSIS

Taking into consideration reports on Special Studies.

GENERAL HISTORY

White Female Married Age 26 years

CHIEF COMPLAINTS

Headaches
Cessation of menstruation
Increased growth of hair on face, chest and abdomen.

PRESENT ILLNESS

The present symptoms began seven months ago with headaches, cessation of menstruation and an increasingly evident growth of hair on the upper lip, the chin and sides of the neck, the front of the chest and between the umbilicus and the symphysis. She has also noticed a complete loss of libido and a tendency to emotional instability.

The headaches are described as follows: They usually occur after she has been lying down for a short time, beginning with a sense of fullness at the base of the skull, gradually increasing in intensity as they radiate up through the head and eventually developing into a severe headache, involving particularly the frontal region and above and below the left eye; this headache is relieved by the taking of aspirin. She invariably awakens between three and five o'clock in the morning with a heachache, so intense that she must get up and take some sedative for relief; also, when she first goes to bed, especially if she retires early, the headache will develop, and will require some sedative. It does not bother her so much in the daytime, although it will occur to some degree, especially as the day goes on. The headache is not accompanied by any definite visual disturbances, nor dizziness. She has had no vomiting spells, but has noticed on a few occasions a tendency to nausea. The other symptoms and signs which have been noticed, namely, the absence of menstruation, the increased growth of hair, and the loss of libido, have all developed concurrently with the headaches. There has been no change of weight. She has not noticed any increase in urine, but a persistent and excessive thirst. Her emotional disturbance is rather indefinite and may be due

merely to the fact that she has worried as to the possible significance of these definite changes in her physical and sexual make-up. On a few occasions, when the headache would begin to develop she would burst into tears without any particular reason, this even occurring in the evening when out socially. She is bothered with a sense of heaviness of the eyelids when she begins to read, this being so marked that she has almost given up any regular reading.

These symptoms have been present to varying degrees since the onset seven months ago, but varied in intensity. They were particularly bad five months ago, and one month ago and for the past two weeks has been particularly ill with headaches, thirst, and general vague, nervous disturbances.

PAST HISTORY

There is no history of any acute or chronic illness. Always active and energetic, and enjoyed athletics although "easily exhausted." No history of any headaches or trouble with the eyes, ears, nose, throat, heart, lungs, gastro-intestinal or genito-urinary tracts in the past.

Menstrual and marital history—Menstruation came on at the age of 13, was quite regular, lasting seven days but so profuse that it was suggested that she have an operation, although this was not done. Married five years ago; first pregnancy, child now four years old living and well, pregnancy normal. Nursed the first child for seven months, then became pregnant and miscarried in two months, following miscarriage bleeding continued for one month, eventually stopped after a vaginal packing. The third pregnancy was normal throughout, child born thirteen months ago, six months before present illness was first noticeable. The menstruation resumed itself one month after the delivery and continued about five months although she nursed the baby three months. The baby was weaned because the milk was inadequate as to quality although abundant in amount. The milk flow continued for three more months but she attributes this to the fact that she used a breast pump.

Habits—regular as to hours of eating and sleeping.

Family history—father had a stroke at 53, lived for three years longer and then committed suicide fearing another stroke. Mother is living and well. One sister older and one brother younger than patient, both are living and well.

PHYSICAL EXAMINATION

GENERAL

Height 69 inches Weight 142 pounds Temperature 97°

Patient shows normal skeletal development, although the frontal prominences above the eyes may be slightly greater than the average. No asymmetry of the facial movements. She does not show any emotional instability at the present time, nor does she seem abnormally introspective or neurotic. No cyanosis, jaundice or eruptions.

HEAD AND NECK

Ears—negative. Eyes—pupils are equal, react normally, associated movements are normal. No signs of mystagmus. Mouth —most of the teeth are missing, the patient wearing partial dentures. The tongue is normal in appearance, protruded in the midline. Throat—tonsils are rather large, quite ragged and show numerous infected crypts. Glands—no general enlargement. Thyroid—not enlarged.

THORAX

Lungs are clear throughout.

Heart—normal size, rate is 58, regular in force and rhythm; sounds are all clear, no murmurs. Pulse—58, regular, no abnormal thickening of vessel wall.

ABDOMEN

No masses or areas of tenderness. Spleen is not felt; liver to costal margin, edge not felt. Right kidney is palpable four fingers' breadth below the costal margin, does not seem tender or enlarged. No abnormality can be felt over the lower abdomen, although the patient complains of a slight sense of soreness on deep palpation.

EXTREMITIES

There is no edema; reflexes are all normal and equal; no tremor. Sensory tests are all normal. Romberg is negative.

There is a definite profuse growth of dark hair over the upper lip and there evidently has been some abnormal hair growth on the chin, the patient stating that this was recently removed. There is also some hairy growth over the sternum, this consisting mostly of scattered, long, dark hairs. The growth over the lower abdomen extends from the symphysis to the umbilicus, being of the masculine type of distribution and quite profuse. The hair of the legs is only profuse below the knees, this being hardly more than one frequently sees even in the female. There is no evidence of abnormality of the bones of the hands or feet.

BLOOD PRESSURE

Systolic 115.
Diastolic 80.

NOTES

MY PROVISIONAL DIAGNOSIS

Based on History and General Physical Examination only.

MY REVISED DIAGNOSIS

Taking into consideration the reports requested on Special Studies.